

Case Number:	CM15-0014896		
Date Assigned:	02/02/2015	Date of Injury:	06/25/2010
Decision Date:	03/20/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/26/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 40-year-old male, with a reported date of injury of 06/25/2010. The diagnoses include cervical degenerative disc disease with disc protrusion and radiculitis, lumbar degenerative disc disease with disc protrusion and lumbar radiculopathy. Cervical MRI (2 Jun 2014) showed discogenic changes at C4-5 and C6-7. Lumbar MRI (13 Sep 2012) showed mild degenerative disc disease with small disc protrusions at L4-5 and L5-S1. Lumbar MRI (17 Dec 2014) showed mild to moderate degenerative changes. Urine tox screen Jun 2014 was inconsistent with prescribed medications. Treatments have included medication (cyclobenzaprine, tramadol, Naprosyn, Protonix and ibuprofen cream). The progress report dated 12/19/2014 indicates that the injured worker complained of low back pain with radiation to the right leg. The objective findings included tenderness of the bilateral paraspinal muscles, decreased range of motion, tenderness at the sciatic notch, and positive left straight leg raise test. The treating physician requested a lumbar epidural steroid injection. The rationale for the request was not indicated. On 04/09/2014, Utilization Review (UR) denied the request for a lumbar epidural steroid injection (levels not given), noting that there was no evidence of strength deficit, reflex change or abnormal sensory exam, no indication of an acute radiculopathy or recent flare-up, and the level of the epidural steroid injection was not provided. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

LUMBAR ESI (LEVEIS NOT GIVEN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-10, Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 39-40, 46.

Decision rationale: The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations is for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. In the documented care for this patient these criteria are not met. Even though the history is compatible with a possible radiculopathy, this is not supported by the exam, which is non-specific for a radiculopathy. Additionally, the degenerative changes in the lumbar spine noted on the lumbar MRI are non-specific and do not describe nerve impingement. Finally, the patient is not undergoing or scheduled to undergo other physical rehabilitation therapies. Thus, the patient does not meet the criteria for this requested therapy. Medical necessity for this procedure has not been established.